KIDS ZONE DENTISTRY – CHILD HEALTH HISTORY FORM

TODAYS DATE: _____

Patient Name: _____ _____ **Date of Birth:** _____
Last First MI (Preferred Name)

IF YOUR CHILD HAS BEEN SICK WITHIN THE LAST WEEK PLEASE STOP FILLING OUT PAPERWORK AND TAKE IT TO THE FRONT DESK NOW!

Does your child ***HAVE*** or ***EVER HAD*** any of the following? Please ***check and/or CIRCLE*** ALL that apply:

- ☐ Acid Reflux/Heartburn
- ☐ ADD/ADHD
- ☐ Allergy to Codeine
- ☐ Allergy to Food
- ☐ Allergy to Latex
- ☐ Allergy to Penicillin
- ☐ Allergies Seasonal
- ☐ Autism
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Angina/Chest Pains
- ☐ Arthritis
- ☐ Artificial Joints/Bones
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bladder Problems
- ☐ Bleeding Disorders/Blood Thinners
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy/ Radiation
- ☐ Cerebral Palsy
- ☐ Cold Sores/Fever Blisters
- ☐ Cysts/Growths/Tumors
- ☐ Diabetes
- ☐ Developmental Disorders
- ☐ Downs Syndrome
- ☐ Eating Disorder
- ☐ Ear or Hearing Problems
- ☐ Epilepsy/Seizures
- ☐ Eye Problems
- ☐ Fainting/Dizziness
- ☐ Gastrointestinal Disease/Stomach Prob/Ulcers
- ☐ Head/Mouth injury
- ☐ Heart Conditions/Disease
- ☐ Heart Murmur/MVP
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ Shots/Immunizations Current
- ☐ Kidney Problems
- ☐ Jaundice
- ☐ Measles/ Mumps
- ☐ Mental/ Learning Disabilities
- ☐ Mononucleosis
- ☐ Nervous Disorders/Anxiety
- ☐ Pacemaker/Defibrillator
- ☐ Pregnancy/Due Date_____
- ☐ Premed Needed
- ☐ Osteoporosis
- ☐ Respiratory/Breathing Problems or Treatments
- ☐ Rheumatic Fever
- ☐ Physically Impaired/Birth Defects
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Speech Problems
- ☐ Stroke
- ☐ Surgery
- ☐ Thrush
- ☐ Thyroid Problems
- ☐ Tobacco/Drug Use
- ☐ Tuberculosis
- ☐ Sexually Transmitted Disease
- ☐ Skin Conditions/Eczema

Please answer all following questions with yes or no. If yes, please explain.

- Is your child taking any **medications** and/or OTC drugs? _____
- Has your child EVER had **heart problems/ been to a cardiologist** or taken **PREMED** for dental treatment? _____
- Is your child **allergic to any medications, foods, and/or other**? _____
- Has your child EVER had surgery anywhere in their body? ANY METAL/SCREWS? _____
- Has your child EVER been diagnosed with any **medical or behavioral condition/disease** not listed? _____
- Has your child been sick or been to the hospital recently? ***IF YOUR CHILD HAS BEEN SICK WITHIN THE LAST WEEK THEN STOP FILLING OUT PAPERWORK AND TAKE IT TO THE FRONT DESK NOW!*** _____
- Has your child ever had any complications following dental treatment? _____
- Has your child ever had a bad dental experience or dislike the dentist for any reason? _____
- Has your child ever had excessive bleeding when cut? _____
- When was your child's last dental visit and for what? _____
- Has your child ever had head, mouth, or teeth injuries? _____
- Does your child have or had braces/orthodontic treatment? _____
- How often does your child brush and floss? _____
- Has your child had issues with sucking their thumb and/or pacifier? _____
- Is your child having any pain or concerns with their teeth? _____
- Does your child ever go to bed with a bottle or sippy cup? _____
- What does your child normally drink? _____
- What does your child normally eat for snacks? _____

To the best of my knowledge, all of the above answers and information provided are true and correct. If I ever have any changes any my health, I will inform the doctors at my next appointment.

_____ _____
Signature of parent or guardian Date Relationship to Patient

PATIENT INFORMATION Today's date: _____

Patient's Full Name: _____ Preferred Name:_____
Patient SS# _____ Gender:_____
Home Address: _____City:_____State:_____Zip:_____
Home Phone: _____ Email: _____
Child's Doctor: _____ Doctor's Phone: _____

WHO IS THIS PATIENT'S ***LEGAL*** GUARDIAN? _____ Relationship _____

Mother's Name: _____
Mother's Date of Birth: _____ SS#:_____
Mother's Cell: _____
Mother Employed By: _____
Occupation: _____ No. of years: _____
Work Phone: _____ ext. _____

Father's Name: _____
Father's Date of Birth: _____ SS#:_____
Father's Cell: _____
Father Employed By:_____
Occupation:_____ No. of years:____
Work Phone:_____ ext. _____

Parents Marital Status: (please circle) Married/ Single/ Separated/ Divorced /Widowed
Preferred Phone contact: (please circle) Home / Cell / Work MOM / DAD

Person responsible for account: _____
Name of Dental Insurance, If Any:
INSURANCE:_____ Id#:_____
Group#:_____ Name of Insured:_____
Insured SS#:_____ Insured DOB:_____

Consent for Services

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment and procedures or tests differing from original treatment plan that may arise from unforeseen conditions, mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I hereby authorize doctor to perform surgical procedures, which include but are not limited to frenectomies and extractions, in or around the mouth and dispose of any tissue or parts which are removed. I am fully aware these procedures embody certain risk. I understand that I can ask for a complete recital of any possible complications before, during and after treatment.
4. I agree to the use of anesthetics, nitrous oxide, sedatives and other medication as necessary. I fully understand that using anesthetic and nitrous oxide agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications before, during and after treatment.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge(18%APR) may be added to my account. If required, I also understand a check of my credit history may be made.
6. I hereby grant to C.H. Pitts Enterprise, Inc. (the Company) my permission and the non-exclusive, irrevocable and unrestricted right to use my likeness in a photograph or in a video in any and all of its publications, including website entries, and in any and all other mediums, now known or later developed (my photograph), in perpetuity, without payment to me by the Company or my receipt from the Company of any other form of consideration. I agree that my photograph will become the property of the Company and will not be returned to me. I hereby irrevocably authorize the Company to edit, alter, copy , exhibit, publish or distribute my photograph, in whole or in part, or purposes of advertising the business of the Company or for any and all other lawful purposes. I hereby waive the right to inspect or approve the finished product, including written or electronic copy, wherein my photograph appears. I hereby hold harmless and release and forever discharge the Company, its representatives, successors and assigns from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization and release.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ _____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party